SOUTHCENTRE
HEALTH & WELLNESS

Dr. Amanda McKenzie | B.Sc, DC

Child's Name: _____

Parent's Names: _____

Address: _____

City: _____ Prov: _____ Postal: _____

Home Ph: _____ Cell Ph: _____

Email Address: _____ Alberta Health Care#:_____

Date of Birth: MM/DD/YYYY Age: _____ Sex: _____

Purpose of this Appt: _____

_____

How would you like to receive your appointment reminders: ___Phone ___E-Mail ___Text Message*

*CELL PHONE PROVIDER(required for TEXT reminder) **CIRCLE:** Bell/Telus/Fido/Koodo/Virgin/Rogers/PC Mobile

How did you hear about our office? _____ If referred, who can we thank? _____

Pregnancy/Delivery History

Type of Birth: _____Normal Vaginal_____Forceps_____Breech_____Cesarean_____Home_____ Birthing Centre_____ Hospital

Apgar Scores: _____ Any Presence Of: _____Jaundice (Yellow) _____Cyanosis (Blue)

Birth Weight: _____ Birth Length: _____

Current Weight: _____ Current Height: _____

Problems During Pregnancy: _____

Problems During Delivery: _____

Congenital Anomalies/Defects: _____

Obstetrician/Midwife: _____
(Name) (Located at)

Pediatrician/Family MD: _____
(Name) (Located at)

Date of last visit to Doctor: _____ Purpose of visit: _____

Infant Feeding: _____Breast _____Bottle _____Formula

Of hours of sleep per night: _____ Quality of sleep: _____Good _____Fair _____Poor

Ph: 403.271.1081 | **Fax:** 403.271.4913

173 Southcentre Mall | 100 Anderson Road S.E. Calgary, Alberta | T2J 3V1

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Developmental History

At what age did this child…?

_____ Respond to sound

_____ Follow an object with his/her eyes

_____ Hold head up

_____ Sit Alone

_____ Crawl

_____ Stand

_____ Walk alone

Childhood Diseases: (Please check all applicable)

_____Chicken Pox _____Rubella _____Mumps _____Rubeola _____Measles _____Whooping Cough

Others: _____

Immunization History: _____

_____

Has your child ever been treated on an emergency basis: ☐Yes ☐No

Describe: _____

Has This Child Ever Suffered From:

- ☐ Dizziness
- ☐ Diabetes
- ☐ Arthritis
- ☐ Neuritis
- ☐ Anemia
- ☐ Poor Appetite
- ☐ Bed Wetting
- ☐ Fainting
- ☐ Neck Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Tuberculosis
- ☐ Headaches
- ☐ Digestive Disorders
- ☐ Rheumatic Fever
- ☐ Hyperactivity
- ☐ Convulsions
- ☐ Walking Problems
- ☐ Arm Problems
- ☐ Blood Disorders
- ☐ Heart trouble
- ☐ Hypertension
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Orthopedic Problems
- ☐ Sugar Concentration
- ☐ Paralysis
- ☐ Broken Bones
- ☐ Leg Problems
- ☐ Stomach Aches
- ☐ Chronic Earaches
- ☐ Colds/Flu
- ☐ Allergies
- ☐ Constipation
- ☐ Diarrhea
- ☐ Behavioral Problems
- ☐ Muscle Jerking
- ☐ Ruptures/Hernias
- ☐ "Growing Pains"
- ☐ Other

Explain:

_____

_____

_____

Surgery: _____

Medications: _____

Accidents: _____

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Authorization For A Care Of A Minor

I hereby authorize this clinic and its Doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

Dated this _____ day of _____, 20_____

_____ _____
Patient Signature (Legal Guardian) Witness Signature

_____ _____
Name (please print) Name (please print)

Responsibilty Of Fees

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.

Dated this _____ day of _____, 20_____

_____
Patient Signature (Legal Guardian)

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft- tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a awhile.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre- existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off an travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

  Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted with the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care.
Inform your chiropractor immediately of any change in your condition.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT CONTINUED

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me. DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

_____
Name (please print)

_____ _____
Signature of Parent or Legal Guardian DATE

_____ _____
Signature of Chiropractor DATE

OFFICE FINANCIAL POLICY

Cancellation Policy

The time you have booked for your appointment is valuable. If you will not be able to attend a scheduled appointment, it is your responsibility to call the office with at least 24 hours notice to reschedule it. Failure to do so will result in 100% of the appointment cost being charged to you.

Direct Billing

Insurance Company_____ Name of Plan Holder_____

ID #_____ Policy#_____

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

Date: _____

_____ _____
Patient or Legal Guardian Signature Witness Signature

_____ _____
Patient Name (please print) Witness Name (please print)

Appointment Reminders

Please understand that it is your responsibility to keep booked appointments. As a courtesy we offer email/text message reminders. If for whatever reason you do not get a confirmation by text or email, it is still your responsibility to be on time for this appointment.